

**Reply to: Comments on the
«Clinical practice guidelines
for assessment and treatment
of transsexuality» issued
by the sexual identity and
differentiation group of the
SEEN (GIDSEEN)[☆]**



Respuesta a: Comentarios sobre las «Guías de práctica clínica para la valoración y tratamiento de la transexualidad», emitidas por el Grupo de identidad y diferenciación sexual de la SEEN (GIDSEEN)

Sir, we are sending this letter as coauthors of the *Clinical practice guidelines for the assessment and treatment of transsexuality* of the sexual identity and differentiation group of the SEEN (GIDSEEN).¹ Standard cross-gender hormone treatment for adult transsexuals with opposite sex hormones and the increasingly common approach of puberty suppression in adolescents with discordance between gender identity and biological sex (GID) assign a crucial role to endocrinologists among the different subspecialties involved in the care of these people, as stated in recent guidelines of the *Endocrine Society*² and the *World Professional Association for Transgender Health (WPATH)*.³ In this issue of *ENDOCRINOLOGÍA Y NUTRICIÓN*, Wittich reflects in her letter to the editor on the care provided to transsexual people in Spain and assesses the recent guidelines issued by the GIDSEEN working group, pointing to a lack of clarity and update, and to the unnecessary requirements still being made in these clinical practice guidelines (CPGs).⁴

We agree with the author on the need for the harmonization of health care to subjects with GID throughout Spain, and on the need for a treatment approach which focuses on the patient, and consider as essential the principle of access to resources, as well as the provision of services with a high quality of care, which were the objectives when CPGs were developed by the GIDSEEN.¹ However, we disagree with some of the opinions of the author, and some of her statements do not agree with the CPG's contents.

Wittich disagrees with the idea that the diagnostic-therapeutic approach should only be implemented at gender identity functional units by interdisciplinary working groups, allowing for open and constant communication between the specialists involved in care to subjects with GID, as stated in international CPGs.^{3,5-10} As in other fields of medicine, the provision of high quality care services requires a multidisciplinary team (rather than the simple transmission of

information between professionals), and this allows in turn for the development of national research projects where the different gender identity units can work in concert to advance in their understanding of this clinical condition and to improve the care and quality of life of these patients.

Hormonal interventions are only indicated once a comprehensive psychological evaluation has confirmed not only that DSM diagnostic criteria have been met, but also that the patient is ready for transition to the other sex.⁷ In the most recent DSM-5,¹¹ the term «gender identity disorder» has been removed and replaced by «gender dysphoria», defined as «a marked incongruence between experienced/expressed gender and assigned gender». The author points out that the WPATH requires deep evaluation, but disagrees that psychological evaluation is a prolonged process. The duration of this evaluation will depend on the characteristics of each individual patient, but evaluation for 4–6 months is usually required.^{2,5} Real life experience (RLE) is important to give an idea of the new gender condition, which allows patients to get accustomed to the social interactions associated with it. RLE should however be adapted to the possibilities in each individual case during the sex reassignment process.² Such sex assignment, by allowing patients to experience life as a person of the desired sex, decreases gender dysphoria and improves social and sexual function.¹² RLE is one of the criteria for starting cross-gender hormone therapy in the CPGs of GIDSEEN and most other CPGs,^{1,2,7,8} but it was not included in the last version of the WPATH standards,⁴ in which it is however a criterion for genital reassignment surgery. The rationale for RLE as a recommended criterion, provided the psychosocial environment of the person allows for it, is based on a consensus of clinical experts, on the basis that RLE provides patients with an ample opportunity to experience and socially adapt to the desired gender role before undergoing cross-gender hormone therapy and, subsequently, irreversible surgery.

It is not true that the authors of the GIDSEEN CPGs «believe in speculative genetic and hereditary factors which have not yet been proven» and «deny the impact of sex steroids on brain development and function», as stated by Wittich. The GIDSEEN only expounds in an objective way the most relevant scientific literature on this subject, as appropriate in CPGs, which should not contain private «opinions». The CPGs of GIDSEEN textually state: «Genetic studies on behavior disorders in childhood suggest a hereditary component. However, except for gender dysphoria secondary to certain sex differentiation disorders, no clear information is available about the etiopathogenesis of gender identity disorders in childhood, and since dysphoria does not persist during adolescence and adulthood in most cases, these data cannot be extrapolated to adults. There is inadequate knowledge of the effects of sex steroids on brain development and function for identifying the biological bases of the formation of gender identity in humans. To sum up, neither biological nor psychological studies provide a satisfactory explanation for the occurrence of this condition at these ages». The currently available evidence is too limited to allow us to reach a definitive conclusion with regard to one or some of the biological factors causing GID.¹⁰ A multifactorial etiology appears the most plausible from a biopsychosocial perspective.

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Refs. 12–16 in the CPGs, considered “obsolete” by the author, were published between 2004 and 2007.

As regards the prevalence of transsexualism (DSM-4) or gender dysphoria (DSM-5), it appears inappropriate to base estimates of the prevalence of this clinical condition on two studies showing that 1% of the population has «some degree» of gender dysphoria. When we speak of the prevalence of GID, it should be stressed that no specific, formal epidemiological studies have been conducted on GID incidence and prevalence, and that efforts to achieve realistic estimates have been fraught with difficulties.¹³ Estimated prevalence rates at European and national level reported in indexed journals and included in the GIDSEEN CPGs¹ and in *WPATH-Standards of Care*³ are 1:11,900–45,000 for male-to-female transsexualism and 1:30,400–200,000 for female-to-male transsexualism. As stated in the GIDSEEN CPGs, these values very likely underestimate the actual prevalence of this clinical condition. However, extrapolation to our environment of findings from studies not published in scientific journals or reported in non-indexed journals and which also conflict with the available evidence would not be scientifically rigorous.

In conclusion, the «*WPATH-Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th version, 2011*» is a document serving as a guide for professionals involved in the integrated treatment of transsexual patients, but both these standards and all other clinical guidelines should be applied in the setting of professional practice. The GIDSEEN clinical guidelines¹ are based on these and other guidelines published in our field, and on the (scientifically rigorous) documented and peer-reviewed clinical experience of specialists in endocrinology, psychology, and psychiatry accumulated during decades of work, and their sole objective is to improve the integrated care of transsexual people.

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